



EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES  
DEPARTMENT OF PUBLIC HEALTH  
DIVISION OF HEALTH PROFESSIONS LICENSURE  
239 CAUSEWAY STREET, SUITE 200  
BOSTON, MA 02114  
800-414-0168  
[www.mass.gov/dph/boards](http://www.mass.gov/dph/boards)

BOARD OF RESPIRATORY CARE  
REQUEST FORM

Use this form to request a name change, address change and/or request for duplicate license.  
Mail requests to the address above to the attention of the Board.  
Check all that apply:

☐ NAME CHANGE      ☐ ADDRESS CHANGE      ☐ DUPLICATE LICENSE

[NOTE: IF YOU ARE REQUESTING A NAME CHANGE AND HAVE A CURRENT OR EXPIRED LICENSE WITH ANOTHER BOARD(S) WITHIN THE DIVISION, THE REQUESTED NAME CHANGE WILL BE EFFECTIVE FOR ALL BOARDS. ]

Print/type clearly the information as it  
**CURRENTLY SHOWS** on your license:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State: \_\_\_\_\_

Print/type clearly the information as you  
wish it to appear on your **NEW** license.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

For a name change, you **MUST** return your current license and submit documentation. **DO NOT** submit original documents; they will not be returned.

Check document submitted: marriage certificate \_\_\_\_\_ divorce decree \_\_\_\_\_ court documents \_\_\_\_\_ other: \_\_\_\_\_

Board Code: **RC**

Lic. No: \_\_\_\_\_

Lic. Type: \_\_\_\_\_ FL \_\_\_\_\_ LP \_\_\_\_\_

SSN (Mandatory): \_\_\_\_\_

Birth Date: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Circle other professional licenses held: Nursing    Pharmacy  
Dentistry    Physician Assistant    Perfusion  
Nursing Home Administrator

**For official use only:**

Fee: \_\_\_\_\_ Date Received: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_

Name: \_\_\_\_\_

If your current license has been **lost or stolen**, please check here. \_\_\_\_\_

For address changes only, do not return your current license. All addresses are subject to disclosure upon request, pursuant to MGL, Ch.4, Section 7.

Under the penalties of perjury, I declare that the information provided herein is a truthful and complete statement of the information required.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Date

**FEES:**

- |                                 |         |
|---------------------------------|---------|
| 1. Duplicate License            | \$17.00 |
| 2. Name change with new license | \$27.00 |
| 3. Address changes only         | no fee  |

**Make check or money order payable to the Commonwealth of MA.  
DO NOT SEND CASH OR ELECTRONIC FUNDS TRANSFERS**